



AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

I, _____, of _____ authorize the
Department of Social and Health Services to Disclose the following records to:

NAME OF PERSON AUTHORIZED TO RECEIVE INFORMATION

ADDRESS OF PERSON AUTHORIZED TO RECEIVE INFORMATION

I authorize disclosure of all personal information except the following:

This authorization remains effective until:

CASE NUMBER

PRINT NAME

SIGNATURE OF CLIENT

ADDRESS OF CLIENT